

Wisconsin: Memory Care Connections

Project Narrative

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Project Narrative

Summary/Abstract

The Wisconsin Department of Health and Family Services (DHFS) seeks funding for four demonstrations of Memory Care Connections, a model of local collaboration aligning dementia services provided by diagnostic clinics, Aging/Disability Resource Centers, Alzheimer's Association Chapters and service providers. The goal is to provide individuals and families affected by Alzheimer's disease with the information, medical diagnosis and management, caregiver support and services needed to achieve improved quality of life through closely connected local dementia services networks. Local sites will be funded to deploy nurses/social workers to link consumers with the dementia service network. The objectives are to increase early identification and treatment; improve timely access to appropriate medical intervention and social services; enable Aging Resource Centers or care managers to do brief cognitive screening as well as comprehensive functional screening; delay nursing home admissions; provide consistent access and continuity of services to caregivers; and establish a framework for achieving quality of life outcomes. The project is a partnership between DHFS, University of Wisconsin Medical School Alzheimer's Institute, established dementia diagnostic clinics in four participating counties, and the Alzheimer's Association.

1. Problem Statement

In the Wisconsin public health plan *Healthiest Wisconsin 2010*, Alzheimer's disease (AD) appears in the highest quadrant of adverse health conditions because of its magnitude and

severity. The toll on caregivers and the cost to the public and private health care systems is enormous and will grow in the coming decades. Population projections are so alarming that the future numbers of persons with AD and other dementias is rightfully described as epidemic.¹ There is an urgent need to plan and develop models of response to prepare for the impending demand for memory care.

Wisconsin has several strong elements in its health and human services systems that provide considerable benefit to persons with dementia and their families. These include: (1) the Wisconsin Alzheimer's Institute at the University of Wisconsin (UW) Medical School; (2) out spread dementia diagnostic clinics strongly supported by the UW Medical School; (3) vigorous chapters of the Alzheimer's Association; (4) the county-administered Community Options Program home and community based services (HCBS) waiver providing resources for care at home and in residential facilities, and in five counties an integrated managed long term care program called Family Care; (5) model Aging and Disability Resource Centers operated by counties; (6) a state Alzheimer's Family Caregiver Support Program and the National Family Caregiver Support Program; (7) a model Dementia Service Bank. In addition, Wisconsin has a number of adult day care programs, well-regulated nursing homes and assisted living facilities committed to serving persons with dementia. These represent strong building blocks for an outreach and delivery system for people experiencing Alzheimer's disease and other forms of dementia.

Despite these resources, major **problems** remain.

- Most people experiencing dementia communicate first with family physicians that do not diagnose or treat the disease.^{2,3}

- Individuals do not receive early diagnosis and treatment when medications and interventions can be most successful.⁴
- Medical practitioners do not know about or facilitate referrals to community-based supports for people with dementia.⁵
- Consumers and their families are usually unaware of the value of early identification, or of resources that could help them cope with dementia.
- Community-based organizations and Aging and Disability Resource Centers do not routinely screen for memory disorders when providing assessments and referrals.
- Few communities include all of the components of a successful dementia care network, particularly in rural areas or cities with high concentrations of minority elders.
- There are few interdisciplinary approaches to managing dementia care in the state.
- There are inconsistent expectations of person-centered care or quality, or measures of successful outcomes among providers and consumers.
- Waiting lists for people who are elderly or have physical disabilities (including younger adults with dementia) seeking Community Options Program waiver resources are lengthy. There are lengthy waiting periods for diagnostic services, undermining the effort to encourage early intervention and treatment.
- Family Caregiver Support Programs lack adequate funding for respite care.
- Most importantly, there are no formal connections between all of the stakeholders at the community level to assure that consumers have timely access to whatever resources will best respond to their needs. Too often, entering the system through one “door” provides access only to one resource.

Wisconsin needs a system of dementia care in each county or region that is characterized by formal collaborations, appropriate inter-disciplinary referrals and follow-up, and cooperative efforts to maximize local resources. Consumers need awareness of opportunities for diagnosis and treatment of memory disorders, knowledge of local resources, assistance regardless of income or eligibility, and quality outcomes.

2. Goal and Objectives

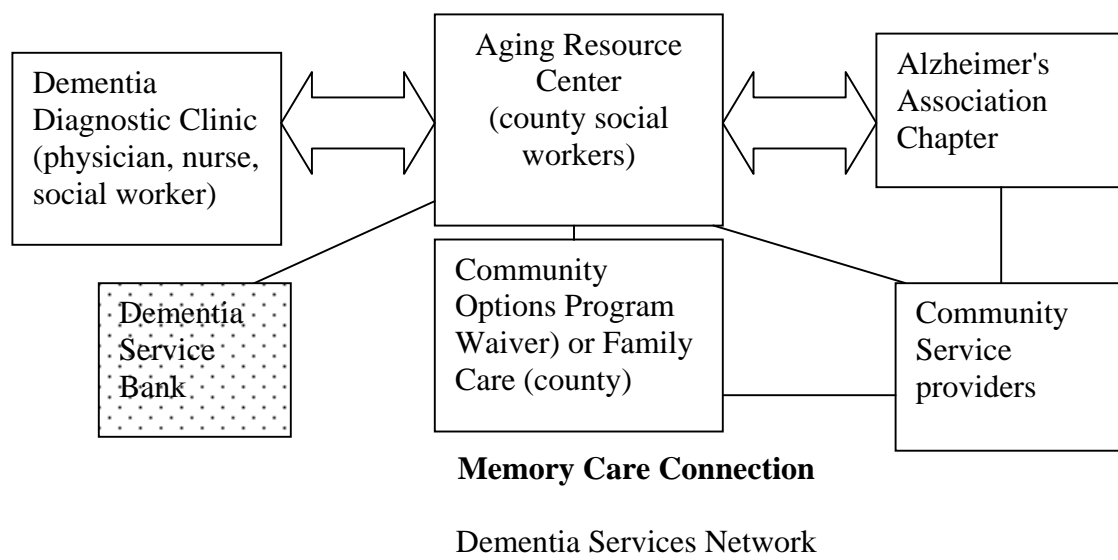
Goal: Provide to individuals and families affected by Alzheimer's disease the information, medical diagnosis and management, caregiver support and services to achieve quality of life, through closely connected local dementia services networks called Memory Care Connections.

Objectives:

1. Increase early identification and treatment of persons with Alzheimer's disease and other dementias.
2. Improve access for people affected by dementia to appropriate medical intervention and services.
3. Demonstrate how Aging and Disability Resource Centers can incorporate cognitive screening and referral to dementia care resources.
4. Prevent or delay admissions to nursing homes for dementia care.
5. Provide consistent access, support and continuity of services for family caregivers through a system with "no wrong doors."
6. Establish a common framework for providing person-centered care and achieving individual outcomes of quality of life.

3. Interventions

Wisconsin Department of Health and Family Services (DHFS) proposes to fund three to five projects in single or multi-county areas to support the development of closely knit dementia care networks. The project is called Memory Care Connections. Its purpose is to enable people affected by Alzheimer's disease to get timely diagnosis, treatment, person-centered supportive services, and caregiver support to achieve individual quality of life outcomes. Through a competitive request for proposal (RFP) process, applications will be solicited from local consortia willing to collaborate to meet the objectives of the Memory Care Connections. The local partners required to form a Memory Care Connection will be: (1) an Aging Resource Center (ARC) or Aging and Disability Resource Center (ADRC); (2) Dementia Diagnostic Clinic(s); (3) an Alzheimer's Association Chapter, and (4) a Community Options Program Waiver (COP-W) care management agency or Family Care, Care Management Organization (CMO). Other possible local partners will include community providers of dementia services such as adult day care or assisted living. The principal convener of the Memory Care Connection will be the Aging and Disability Resource Center.



There are 25 **Dementia Diagnostic Clinics** in Wisconsin. At each of these outpatient health care facilities a trained team including a physician and neuropsychologist social worker conduct a diagnostic protocol for individuals concerned about increasing memory problems. Many clinics have access to multiple practitioners who can provide an integrated approach to treatment of complex symptoms. These practitioners, for the most part, are family practitioners or geriatricians and nurses or social workers who have all received training in dementia. Eighteen of the clinics receive ongoing assistance from Dr. Mark Sager, director of the Wisconsin Alzheimer's Institute (WAI) at the UW Medical School; these clinics are considered WAI affiliated. Since Medicare does not pay for dementia diagnostic screening, there are limited resources for any clinic that offers this service, so hours available for diagnostic work are limited, and waiting time varies between three and six months. Obviously, this lengthy wait reduces the opportunity for early interventions and effective drugs. More than 50 percent of persons with dementia never receive a diagnosis because their own physicians are unable to identify or diagnose the disease.⁶⁻¹⁰ In a recent (2003) study by the WAI of 411 patients assessed at diagnostic clinics, the diagnoses were distributed among patients as follows:

| Diagnoses of Patients at Dementia Diagnostic Clinics in Wisconsin | | | |
|---|-----|-------------------------|-----|
| Normal | 9% | Lewy Body | 5% |
| Mild cognitive impairment | 17% | Frontal Temporal Lobe | 3% |
| Alzheimer's disease (AD) | 34% | Other dementing illness | 10% |
| Vascular | 10% | Non-dementing illness | 3% |
| Mixed | 9% | | |

As this data shows, 88 percent of those tested had some form of dementia. Each diagnosis indicates the need for specific treatment. Early intervention is important according to the *2000 Progress Report on Alzheimer's Disease* (p. 12), "...the earlier an accurate diagnosis of Alzheimer's disease is made clinically, the greater the gain in managing symptoms." By maintaining higher levels of

functioning with new medications, caregivers and people with AD can plan, prepare and delay decline which can reduce dependency and defer out of home placement. The *2001-2002 Progress Report on Alzheimer's Disease* advises that Mild Cognitive Impairment is very often an early stage of AD (Morris, et al. 2001). Current AD therapies have been shown to delay institutionalization by 12-24 months.¹¹⁻¹³ For every 100 persons with dementia sustained in the community, the state or individuals will save \$3.7 million. (Sager analysis) In order to maintain people with dementia in the community, the person and their family need more than current medications. In order to delay nursing home admissions, it is necessary to have willing and able caregivers, and to maintain the person's functional level as long as possible.^{14,15} According to recently published research (Mittleman, *American Journal of Psychiatry*, May 1, 2004), there is strong evidence that spouse caregivers that received enhanced counseling after the disease was evident had substantially less depression a year later compared to a group that only received information. It is valuable for caregivers to either receive extended counseling (four to six sessions) at the clinic or through another community-based organization. A vital function of a Dementia Diagnostic Clinic is to provide resource information and referral for the patient and the family. However, limited funding is a barrier to extensive social work service at these clinics. Physicians and nurses rarely know about available community resources, whether from the county, Alzheimer's Chapters, or service providers. Memory Care Connections will assure that there is a social worker or nurse located at the clinics to effect referrals and follow-up. These are compelling reasons to develop local strategies like Memory Care Connections that would connect physicians and community organizations for the purpose of reciprocal referrals: to physicians for diagnosis and treatment, and from physicians to community-based organizations for counseling and support.

In Wisconsin, there are 10 **Aging or Aging and Disability Resource Centers (ADRC)** funded through the state's pioneering Family Care program that combine multiple funding sources to provide integrated services and one-stop shopping for information and referral. In addition, there are at least 10 more counties that have developed Aging Resource Centers (ARC) with local and Older Americans Act funds not related to Family Care. Many of the remaining county aging offices are striving to become an ARC. The Resource Centers, which were the model for the recent Administration on Aging demonstration grants, have these core functions: to provide to the general public (regardless of income eligibility) outreach, information and assistance, long term care options counseling, prevention and early intervention services, and -- in the state-funded agencies -- the functional screening to determine eligibility for publicly funded long term care. A majority of the contacts made to the ARC's are from family members or older persons looking for service information. Well-trained resource people assist individuals to define their needs and explore options. This provides an opportunity to do a brief cognitive assessment to determine whether the person would benefit from referral to a dementia diagnostic clinic. Using the 60 second verbal fluency screen (VFS)¹⁶ that has been evaluated by WIA, the Resource Centers can advise consumers of the value of getting a memory "check-up" from a physician, and assist with making appointments and even arranging transportation. Through their outreach and public information functions, the ADRC can provide increased public awareness of resources for people concerned about memory loss.

The **Alzheimer's Chapters** provide the core functions of caregiver support and education, community outreach, assistance and education of professionals and advocacy. In Wisconsin the chapters also attempt to offer regional support and assistance to ARC's, yet budget and staffing constraints allow minimal collaboration and consultation efforts. The chapters have the knowledge

and skills to provide counseling and education to the family caregivers who are in contact with the dementia diagnostic clinics, but there is not a formal mechanism for making that connection. Likewise, chapters have limited opportunity to work closely with Aging Resource Centers. A notable exception is the Dementia Service Bank, developed during the previous grant cycle in Milwaukee, as a collaboration between the Southeastern chapter of the Alzheimer's Association, the Aging Resource Center and the service providers who "contributed" service hours to the bank. A recent needs assessment conducted on behalf of the chapters by E jj Olson and Associates (2003) identified recommendations for the association that are closely aligned with this proposal:

- The Alzheimer's Association chapters should promote the development and enhancement of dementia care networks ... to assure interagency dialogue and cooperation, and increase the integration of dementia care services.
- Partner with the WAI to educate physicians and other health care professionals about the importance of early diagnosis and appropriate early intervention to slow the progression of the disease.
- Develop a close working relationship with the local offices on aging...to provide dementia services programming.

The Alzheimer's Association supports this proposal as a new opportunity to fill these gaps. Memory Care Connections project will formalize the working relationships between the chapters and these other partners in the local service network.

The third vital element of the Memory Connection is the **Community Options Program (COP)** in 67 counties or the more comprehensive **Family Care** program in five counties. These two Medicaid waiver programs offer home and community-based services to persons who meet a nursing facility level of care as determined by an automated Long Term Care Functional Screen (LTCFS). Through

this proposal, we will explore the feasibility of using the 60 second verbal fluency screen as a new component of the functional screen. We will also collect data on the functional status of persons screened for COP or Family Care who have dementia. To be served through a waiver, the individuals also meet a financial eligibility for Medicaid based on the special nursing home financial eligibility and a cost-sharing component. The stringent financial eligibility is a barrier to some elderly individuals' participation in the programs and hence access to comprehensive supportive services. For those who are eligible lengthy wait lists for COP are a barrier in most counties. There are 933 people aged 65 and over on county waiting lists for the COP waiver who have Alzheimer's disease. Whether or not these individuals remain outside a nursing home depends on the durability of their caregivers and the creativity of local service agencies to provide interim support services. The **Dementia Service Bank (DSB)**, one way of addressing short-term needs, is a group of dementia care providers who agree to donate some of their services in order to assist people with dementia who are under served and on waiting lists for services, and do not have the financial means to pay privately. Typically these are people who are financially disadvantaged and in many cases from minority populations (African American, Hispanic, Native American, Hmong). A lead agency coordinates the donations and arranges for the care. Under our previous Alzheimer's grant the service bank was tested as a vehicle to provide respite services to these populations, using grant direct service funds in conjunction with donated service. We now propose to use the service bank as a model to be developed in new areas of the state as part of the Memory Care Connection, either operated by the Aging Resource Center or contracted.

Family Caregiver Support services and the volunteers and staff services of Alzheimer's chapters are vital to sustain fragile care arrangements while people wait for COP benefits. This project will formalize the working agreements between these partner agencies to address the needs of persons

on wait lists to the extent possible, including the provision of intermittent direct services through the service bank and/ or paid for from the grant. Such services must be available to respond to crises, such as incidents of dangerous behavior, police calls, personal or health problems of the caregiver, as well as scheduled episodes of respite or transportation. **Family Caregiver Support and Alzheimer's Family Caregiver Support** funds, donated services in the service bank, Interfaith volunteer caregivers and direct service funds from this grant will be available for timely, flexible service responses. Local projects developing needed caregiver support or seeking new approaches to reduce caregiver stress will be directed to Resources for Enhancing Alzheimer's Caregiver Health (REACH) and other researched models. In the four-five counties that will be selected for this project, we expect to serve a total of at least of 400 persons each year. Fortunately, the counties covered by the Family Care program do not have wait lists. If any of these are chosen for the project, the vital connection is between the Dementia Diagnostic Clinics, the Aging Resource Centers and Family Care to provide early intervention, and long term care options counseling to prepare for the consumer's future decline. Grant funds will pay for persons who do not yet meet the functional and financial eligibility of the waivers.

Optional partners in the local Memory Care Connection will be selected "dementia capable" providers of home and community based services, including respite. While there may be multiple service providers in any service area, it is important to include some of the highest quality providers of adult day care and residential services in the development of formal protocols for screening and referral. Providers will be partners in determining how best to fund and provide respite care in any community. The state project coordinator will provide on-going training and technical assistance to the service providers and the care management programs in the incorporation of dementia quality of life outcomes into their practice.

This proposal incorporates **lessons learned** from several projects. In 2000, the Wisconsin Alzheimer's institute (WAI) received a grant to develop a screening instrument to detect mild cognitive impairment. About 10-15 percent of those with mild cognitive impairment develop Alzheimer's disease each year, and mild cognitive impairment is seen as an early warning sign of dementia (*Sager, WAI 5-Year Report, p. 24*). A key rationale for the Memory Connections proposal is that early intervention is key to maintaining the function of persons with dementia and to providing education to the individual and the caregiver. Most older people will not come in contact with the formal long term care system until their disease is well advanced. Individuals with mild memory or cognition problems are afraid to access Alzheimer's Chapter services and are reluctant to seek diagnosis. For this reason, the Aging Resource Center is seen as a likely first call that family members might make, perhaps for information about transportation if they are fearful of their impaired elder's driving. At the Resource Center, Information and Referral specialists will be trained to recommend a functional screen, which will include the verbal fluency dementia screen for which WAI will provide training. Individuals who score poorly will be referred to the dementia diagnostic clinic. A social worker, paid for by this grant, will work with the diagnostic clinic to facilitate additional counseling and service arrangements for persons who need follow-up for dementia, or for reversible cause of cognitive impairment, such as nutrition or medication management. Families will be introduced to the supports and information provided by the chapters, and will learn about respite and other help they may require in the future. Relationships with the Aging Resource Center will be established for ongoing information and support and agencies conducting caregiver support programs will be directed to incorporate interventions based on promising practices reflected in National Institute on Aging research projects.

Another lesson learned by WAI is that primary care physicians do not recognize, acknowledge or treat dementia. WAI is seeking funding for extensive continuing medical education for physicians. Physicians will be introduced to a diagnostic tool screen, and protocols for a diagnosis and treatment. WAI has experience showing that when physicians have better knowledge and tools, their attitude about diagnosis and treatment improve. In the counties or regions selected for the Memory Care Connections project, special outreach to physicians will help them be informed about the local supports and services to which they can refer families, as well as the specialized services of the diagnostic clinics.

Wisconsin benefited from a previous Alzheimer's disease demonstration grant, which was used in part to support outreach to urban minority and low-income elders. The concept of a Dementia Service Bank was developed in Milwaukee to respond to critical situations for people with dementia and their caregivers when community care wait lists were lengthy and prescription medication was not affordable. The Dementia Service Bank will be replicated as a flexible and responsive element of the project.

A major deliverable from the previous funding cycle was the **Dementia Quality of Life Outcomes Care Planning Tool**. The Outcomes were developed by a panel of consumers and experts in dementia care, and focus on the individual value and experience of each consumer. The striking characteristic of the Outcomes tool for care planning is the assumption that there are positive outcomes to be achieved for people with dementia; there is quality of life possible, and there can be hope. All of the partners in the Memory Care Connection will receive training in the effective use of this tool for care planning as well as for outcome-based contracting and quality assurance. The tool can provide a common language and value set for communication across disciplines and agencies.

The communities selected for this project will be required to submit a proposal to DHFS that includes evidence of the participation of all of the necessary components of the Memory Care Connection. Funds awarded may support a professional social worker or nurse, employed by the Aging Resource Center, who might be co-located at the diagnostic clinic on the days of operation. This person will coordinate referrals through the auspice of the Aging Resource Center. WAI will provide training to physicians who request it, as well as training to professionals who will use the verbal fluency screen as part of the functional screening process. The state staff person will provide training and technical assistance in the use of the Outcomes tool.

4. Outcomes

1. Increased numbers of persons in each demonstration site will receive early identification and treatment of dementia.
2. Additional physicians will be equipped to provide diagnostic and treatment services.
3. Older adults with cognitive impairments will be identified and helped as Aging and Disability Resource Centers screen and assist people.
4. Family Caregivers will receive timely assistance in crises.
5. Persons served by selected providers will have person-centered planning and services that achieve desired outcomes.
6. Family caregivers will be knowledgeable about the resources and roles of organizations in the Memory Care Connection.
7. Organizations in the Memory Care Connection will have working agreements and protocols and function as an interdisciplinary team for persons served in this project.

The benefits of implementing the Memory Care Connections project are the ways in which this project will advance the capacity of home and community-based health and social services to

provide effective and holistic treatment and support to persons with AD and their families. As a model that requires collaboration to obtain funding, Memory Care Connections will produce working agreements and protocols that can be adopted elsewhere. In order to make the effort replicable, it is imbedded in the institutions that are present in every community: family physicians, the aging network and /or Aging Resource Centers, home and community-based waivers, and the Alzheimer's Association. The success of this project will demonstrate the value of early identification and treatment, and a focus on quality of life, providing hope to families and individuals. To the extent that nursing home admissions are demonstrably delayed even one year, savings accrue to government and private pay families. Developing low-cost crisis services and respite will demonstrate what can be achieved in communities that take on this challenge.

5. Special Target Populations

Memory Care Connections will be developed in areas of the state that include both urban and rural populations, although most counties in the state are rural. Local projects will be expected to focus special outreach efforts toward at least one minority population, e.g., African-American, Native American, Hmong, Hispanic. Elders served will include low-income elders who are not functionally eligible for waivers or are on waiting lists. Elders will also include persons who are functionally eligible but who have income and assets slightly above HCBS waiver eligibility, but too low to pay for themselves.

6. Evaluation and Dissemination

Evaluation Plan. Sources of data for evaluation will include:

- Long Term Care Functional Screen (LTCFS) used in Aging Resource Centers, COP waiver and Family Care. As a web-based screen, data is transmitted to the state for eligibility and maintained in a data warehouse, along with Medicaid data.

- Aging and Disability Resource Centers collect contact information for the Information and Assistance Service.
- Dementia Diagnostic Clinics provide data on diagnosis and demographics to the WAI.
- Participant interviews conducted as part of the quality oversight for waivers. The same protocol can be used to interview persons served through this project.
- Participant surveys will determine awareness and satisfaction with the Memory Care Connection.
- Participating organizations will develop working agreements (memoranda of understanding) and will meet at least twice each year, providing minutes.

The following methods will be used to evaluate the extent to which outcomes are met:

numbers of persons receiving diagnostic services at clinics will be compared to previous years' screening at the diagnostic clinic; numbers of physicians trained by WAI in each community will be tallied, with follow-up in one year to determine if they are providing diagnostic services; numbers of persons referred by the ADRC will be retrieved from the data collected; profiles of clients with dementia who are screened with the automated LTCFS will be analyzed. In a follow-up one-year later, we will analyze functional changes and where the person is living (and whether they are in a nursing home). Quality of life information will be assessed by service providers using the outcome tools provided. The state will conduct participant feedback through written participant surveys sent by the ADRC, and through a sample of interviews conducted by the waiver quality team. The survey will determine what the participants have learned about the organizations in the Memory Care Connection and how they think they do their jobs. Interdisciplinary team development between the collaborating members of the Memory Care Connection will be demonstrated by protocols for information and referral between organizations, and by minutes from meetings.

Dissemination Plan: A report will be published on the total effort, with county-specific information and sample tools and protocols described, as well as collaboration models and targeted outreach approaches. The report, including a guide for replication, will be posted on the DHFS and the Administration on Aging (AoA) web-sites. Presentations and skill training will be provided at the annual state conferences of the Alzheimer's Association, the COP Long Term Support and Aging Conferences, and at national events such Alzheimer's, Waiver, and the National Council on Aging/American Society on Aging annual conferences.

7. Project Management

The project manager for Memory Care Connections is grant author Donna McDowell, MSS, Director of the Bureau of Aging and Long Term Care Resources, the bureau responsible for managing community-based services for older people and people with physical disabilities. Under the grant, a half-time project staff person will be responsible for day-to-day monitoring and progress of the local effort. Ms. Cathy Kehoe, bureau dementia specialist, was the lead person responsible for the development of the Dementia Quality of Life Outcomes Care Planning Tool under the previous AoA grant proposal and will provide training under this one. Dr. Mark Sager, MD and Barbara Lawrence, BSN, MS, of the Wisconsin Alzheimer's Institute (WAI) will provide training to physicians and professionals on the use of the cognitive screening tools. The RFP soliciting county participation will be managed by a Bureau human service program manager. The Bureau already has two list serves (one for waiver agencies called LTS-Talk and one for the aging network, called Badger Agenet). We will determine whether to establish a new list serve for this project, or rely on e-mail groups for communication. When local projects are selected, this Bureau in DHFS will develop contract specifications including deliverables and timelines for performance. This will include progress reports.

Sub-contractors will be expected to report on progress on these milestones:

- Training persons who will administer the cognitive screen.
- Obtaining active involvement from lead person from each agency on the collaboration team.
- Training team members in collaboration and team building.
- Establishing protocols for referral.
- Recruiting participation and gifts to the service bank.
- Training on Outcomes tool.
- Developing, adapting or applying outreach materials, including specialized material for minority group.
- Hiring or assigning social worker or nurse to lead local project.
- Establishing data collection protocols (HIPAA compliant).
- Defining roles and responsibilities for each partner (e.g., Alzheimer's Association will connect people to safe return program; Resource Center will arrange direct service and obtain participant feedback; clinic will obtain release to share information with service provider, etc.)

The State Aging Advisory Committee will serve as the consumer advisory panel to the project.

The State Council on Long Term Care Reform will be informed about the project on a regular basis.

8. Organizational Capability

As part of the Department of Health and Family Services, Division of Disability and Elder Services, the Bureau of Aging and Long Term Care Resources has responsibility for: Older Americans Act and state aging programs, programs for people with physical disabilities and

assistive technology, adult protective services and the Community Options home and community based waiver for elders and persons with physical disabilities. The Bureau manages the Alzheimer's Family Caregiver Support Program (AFCSP) which was a model for the development for the National Family Caregiver Support Program. The Bureau manages policy as well as contracts for all these programs; these contracts are with units of county government or private providers. Donna McDowell, MSS, Bureau Director, has a 25 year history in developing and/or managing community programs, especially in the areas of aging, elder rights and long term care. Janice Smith, MSSW, Assistant Bureau Director and supervisor of the Long Term Support Section has managed the AFCSP program since shortly after its inception in 1986 as well as grants related to quality, care management and Alzheimer's disease. Both Ms. McDowell and Ms. Smith and staff created the concept of the Alzheimer's Institute and helped it get launched in 1996 and manage the contract for the state funds that support it. In addition, Cathy Kehoe, Alzheimer's specialist, will provide project facilitation, oversight and technical assistance on dementia. For the past three years under the state's current Alzheimer's grant, Ms Kehoe has developed a variety of training models and provided well received training and technical assistance. The Alzheimer's Institute, a center within the University of Wisconsin-Medical School has increased its funding tenfold in the past five years under the leadership of Dr. Mark Sager, M.D. Dr. Sager developed the first memory disorder clinic in Madison and has been responsible for developing and providing ongoing support to 18 currently located throughout the state.

The Bureau of Aging and Long Term Care Resources has successfully managed numerous federal grants and developed strong demonstrations and models. A representative listing of these

grants is provided to demonstrate capability to manage grants and produce products. These projects included:

- Quality Improvement in Home Care developed RESPECT outcome values, care management standards, and a standardized assessment tool.
- Nursing Home Transition Grant relocated over 500 persons who were elderly or physically disabled from nursing homes, and developed a model rural housing cooperative and a direct-care worker owned cooperative.
- WisLoan grant provides loans through a partner bank to individuals and families to purchase adaptive equipment and home or vehicle modification.
- Real Choice Systems Change Grant supported a study of why older persons do not use community care as readily as other groups by conducting focus groups with older people; provided staffing for the new Freedom Initiative Consumer Advisory Committee; supported relocation of persons with mental illness from nursing homes and development of consumer directed personal care.
- Alzheimer's Disease Demonstration Grant from AoA awarded four years ago was used to develop the Milwaukee urban minority outreach effort, the Dementia Service Bank and the Outcomes Tool. In addition, the project produced a curriculum for training case managers, caregivers and service providers to interact with and effectively serve people with dementia. Over 1,000 people received this training.

Work Plan

| Key | MCC - Memory Care Connection DDC - Dementia Diagnostic Clinic WAI - Wisconsin Alzheimer's Institute | ARC - Aging Resource Center AA - Alzheimer's Association Chapter BALTCR - Bureau of Aging and Long Term Care Resources | | | | | | |
|-----------------------|---|--|--|--|--|---------------------------------------|--------|--------|
| Objectives / Outcomes | Tasks | Lead Person | Year 1 | | | | Year 2 | Year 3 |
| | | | Q1 | Q2 | Q3 | Q4 | | |
| | A. Select Local Project Sites <ul style="list-style-type: none"> a. Plan with WAI: role of diagnostic clinics; use of verbal fluency screen b. Identify criteria for projects c. Summarize REACH projects suitable for implementation & dementia service bank & append to RFP d. Write RFP e. Disseminate RFP f. Notify selected projects g. Projects begin | WAI / BALTCR BALTCR BALTCR BALTCR BALTCR BALTCR | X X X X X | X X | | | | |
| | B. Local Project Planning & Start-up <ul style="list-style-type: none"> a. Collaborating agencies have meetings to identify roles & resources of each b. Identify lead for coordination; hire staff c. Identify which agencies will do early identification screen; obtain training d. Identify protocols for referrals e. Provide training to all agencies on use of Dementia Quality of Life Care Planning Tool f. Provide training to projects in community collaboration g. Provide orientation to service models: service bank, caregiver research, minority outreach approaches h. Develop plan for direct service delivery: eligibility (i.e., low income, level of need), services provided i. Plan outreach strategy for minority population j. Plan and set-up data collection methods | Local Local Local / WAI Local BALTCR Contract BALTCR/ Chapters Local Local Local | X X X X | X X X X | X X X X X X | X | | |

| Objectives / Outcomes | Tasks | Lead Person | Year 1 | | | | Year 2 | Year 3 |
|---|---|-------------|--------|----|----|----|--------|--------|
| | | | Q1 | Q2 | Q3 | Q4 | | |
| 1. Increase early identification and treatment <u>Outcome:</u> Persons in each project site receiving early identification and/or treatment will increase 10% in year 1, 20% in year 2, 30% in year 3. Increase in # of minority persons seeking diagnosis. | C. Memory Care Connections Begin: Project Implementation a. Identify criteria for screeners b. Identify those clinicians within MCC team who will be trained & authorized to use verbal fluency screen (VFS) c. Explore feasibility of using VFS within LTC functional screen d. Train screeners e. Organize public awareness of the value of early diagnosis and early treatment, myths of memory impairment, benefits of a “memory check-up”, etc. f. Develop & implement tailored outreach/public awareness for at least one minority group g. Train professionals in relationship of mild cognitive impairment to dementia h. Maintain list of treatment specialists i. Refer for service j. Treat | WAI | X | | | | | |
| | | WAI/MCC | | | X | | X | X |
| | | BALTCR/WAI | X | | | | | |
| | | WAI | | | X | | | |
| | | ARC/MCC/AA | | | X | | X | X |
| | | ARC/MCC/AA | | | | X | | |
| | | WAI/AA | | | X | | X | X |
| | | ARC/AA | | | | X | X | X |
| | | MCC | | | | X | X | X |
| | | DDC | | | | X | X | X |
| 2. Improve access to medical intervention & service. <u>Outcome:</u> Number of physicians indicating interest in AD diagnostics &/or treatment will increase in each site. 1 doctor each year of grant. Increase in number of minority persons accessing medical interventions. | a. Identify general practice physicians, area clinics & other medical professionals who want to learn about dementia b. Facilitate referral of those to WAI or others for training depending on interest: screen, refer, &/or treat c. Seek ways to reduce waiting time for diagnostic service at DDC d. DDC (and other practitioners) refer individuals for caregiver support while waiting for diagnostic work up, instead of after e. Refer consumers to DDC or to trained physicians | MCC | | | X | | | |
| | | MCC | | | | X | X | |
| | | MCC | | | | X | | |
| | | DDC/ARC | | | X | X | X | |
| | | MCC | | | | X | X | X |

| Objectives / Outcomes | Tasks | Lead Person | Year 1 | | | | Year 2 | Year 3 |
|--|---|---|--------|----|--|--|--|--|
| | | | Q1 | Q2 | Q3 | Q4 | | |
| 3. Demonstrate how ARC can screen & refer <u>Outcome:</u> <ul style="list-style-type: none"> ARC performs dementia screens. ARC refers consumers to dementia capable resources. Year 1 - will be base year Year 2 - increase referrals by 10% Year 3 - increase referrals by 20% | a. Explore feasibility of integrating VFS with LTC functional screen b. Explore other models of screening, e.g., having a trained clinician co-located at the ARC once a week or at senior housing * See tasks under objectives 1 and 5 | BALTCR/WAI ARC | | | X | X | X | X |
| 4. Prevent or delay nursing home (NH) admissions for dementia care <u>Outcome:</u> None feasible for this objective. | a. Collect data on NH admissions for dementia in project counties b. Analyze data on numbers served by project, i.e., functional status changes c. Implement intervention related to other objectives (1-3, 5, 6) | BALTCR ARC/ BALTCR MCC | | | X X | X | X X X | X X X |
| 5. Provide access support & services for family caregivers <u>Outcome:</u> 140 people will receive services with AFCSP or grant funds in projects. | a. Train I&A specialists in dementia, early memory problems, handling typical consumer or family questions b. Maintain accurate database for referrals to providers c. Identify service gaps d. Plan an effective service response, i.e., review REACH research and develop interventions, e.g., caregiver counseling e. Ensure providers are dementia capable (see objective 6) f. Develop service bank, if desired g. Deliver, arrange or contract for direct services h. Assess person and family caregivers to determine service needs and initiate services i. Implement strategies to ensure minority population knows of services available and receives culturally appropriate services | BALTCR/AA ARC MCC ARC/AA MCC/AA ARC/MCC ARC ARC MCC/ARC | | | X X X X | X X X X X X X X | X X X X X X X X | X X X X |

| Objectives / Outcomes | Tasks | Lead Person | Year 1 | | | | Year 2 | Year 3 |
|---|---|--|--------|----|----|----|--------|--------|
| | | | Q1 | Q2 | Q3 | Q4 | | |
| 6. Use Dementia Quality of Life Outcomes Tool for service planning <u>Outcome:</u> Waiver care managers will use tool for care planning for clients with AD. At least one new service provider will use tool in year 1, 2 more in year 2, 2 more in year 3. | a. MCC team will receive training in tool b. Care managers in project counties will be trained in use of tool c. Local care providers will be offered training each year of project d. Waiver quality assurance review will report on impact of tool on people e. Providers & consumers (families) will be asked for feedback on value of tool & suggestions for making more useful | BALTCR BALTCR BALTCR/ MCC BALTCR | | X | | | X X | X |
| | | MCC/ BALTCR | | | X | X | X | X |
| | D. Project Management a. Identify data to be collected; collect b. Review quarterly reports c. Conduct quarterly meetings or conference calls to share project progress, challenges, ideas d. Arrange training, if requested e. Prepare federal reports f. Attend annual grantee meeting | BALTCR | | X | | X | X | X |
| | | BALTCR | | | | X | X | X |
| | | BALTCR | | X | X | X | X | X |
| | | BALTCR | | | X | | X | X |
| | | BALTCR | | | X | | X | X |
| | | BALTCR | | X | | | X | X |

10. Appendices

- References
- Dementia Diagnostic Clinic – Map

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11. Letters of Commitment

- Wisconsin Alzheimer's Institute
- Wisconsin Alzheimer's Association Chapter Network
- Alzheimer's Association – Southeastern Wisconsin Chapter
- Wisconsin Association of County Aging Unit Directors
- Dementia Service Bank

12. Project Personnel Vitae

- Donna McDowell
- Dr. Mark Sager
- Cathy Kehoe